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Even ethics professors fail to return library books

Commentary on “A role for philosophers, sociologists and bioethicists in revising the DSM”

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Tamara Kayali Browne’s suggestion to create a formal role in DSM revision for philosophers, sociologists and bioethicists is interesting and stems from a well-supported concern about how nosological psychiatric categories interact with both the epistemic norms of science and philosophy and with their consequences in the world. Browne is grappling with a problem that is clearly stated and pressing. However, I am not convinced that her solution, namely, using experts from these disciplines to form a veto-wielding ethics committee, is an ameliorative to this problem.

Browne identifies a problem: the process of DSM revision involves making value judgements that are not explicitly articulated nor fully disambiguated from scientific judgements about, say, the reality of some psychiatric condition. Browne suggests that a committee formed out of experts about value judgements (philosophers, sociologists and ethicists) may inform the process and halt the production of categories that stem from confusion, ambiguity, or lack of recognition for the underlying causes of the condition. One of her examples, that of Premenstrual Dysphoric Disorder (PDD), suggests that placing the disorder squarely within the symptomatic individual is not true to reality and does a disservice to the suffering person as well as to women in general.

Here are several points in response. First, I agree that psychiatric nosological categories require, indeed demand, the kind of scrutiny Browne advocates. But such scrutiny cannot be limited to a committee made up of a small number of individuals. The categories need to be scrutinised more broadly by advocacy groups, patient fora, discussion groups for health professionals, as well as by scholars and researchers who specialise in the kind of critical reflection required here. Browne seems to support the consultation process undertaken in preparing the DSM-V. However, it is not clear that a small group of experts (about which more below) would improve this already broad and open consultative process.

Second, to relegate the ethical, critical and reflective role to philosophers and sociologists, seems to miss an important point about health professionals in general, and psychiatrists in particular: medicine is an art, as well as a science, and the virtuous or excellent psychiatrist (and medic more generally) is a skilled, thoughtful, and well-informed clinician who is also equipped with additional skills. These include: an attuned sensitivity and knowledge of the phenomenology of the conditions she treats; a deep understanding of how a psychiatric category plays itself out in the real world; a capacity for empathy and understanding of the background and past experiences of patients; a critical ability to question one’s decisions and actions; a reflective stance towards one’s own beliefs and practice; an epistemic humility that drives a continuous desire to improve one’s practice.

There is little reason to believe that a group of experts in philosophy, sociology and ethics, who come into limited contact with the DSM creators and revisers, necessarily have these skills, or have the capacity to develop these skills in psychiatrists. There is no evidence that philosophers and sociologists are more moral or more empathic than academics in other fields. It is also not clear that

their expertise feeds into improved understanding of the conditions and needs of mental health patients.

Moreover, the notion of expertise itself, as applied to ethics, may come under pressure when scrutinised. Take, for example, the work of Eric Schwitzgebel and Joshua Rust, who study the ethical behaviour and beliefs of ethics professors. They have found that the kind of moral training ethics professors have does not make them more likely to behave more ethically or to have a better fit between their moral beliefs and behaviour (Schwitzgebel and Rust 2009; Schwitzgebel and Rust 2014). As they write, “Kantians lie, Confucians disrespect their elders, utilitarians buy expensive coffee” (2009, p. 1044). In fact, ethics professors behave much like anyone else; they vote as frequently as non-morally trained academics, eat meat, leave their seminar room untidy and even misappropriate library books at roughly the same rate as other professors (Schwitzgebel and Rust 2009; Schwitzgebel and Rust 2014). The idea that ethical deliberation is an expertise that lends itself to discussing specific, grounded and empirically complex cases such as the ones raised by the DSM categories thus seems misplaced.

Rather, what is called for, I believe, is developing critical and reflective skills, as well as empathy and listening skills in psychiatrists and those involved in DSM development. This can be done effectively via medical education, professional training, and other modes of engaging with psychiatrists. Here are some examples for avenues for training of this sort.

The field of medical humanities, and more recently critical medical humanities, aims (among other things) to promote a set of skills and attunements in health professionals, by drawing on resources from the arts and humanities. Using literature, medical history, poetry, philosophy, and arts, medical humanities education aims to broaden the horizons of the health professional as well as provide them with reflective and critical skills. It aims to broaden their view beyond the medical.

Philosophy is the discipline perhaps best suited to develop critical and interpretative skills. Philosophy is led by attention to detail, careful conceptual analysis and sensitivity to language. As Rachel Cooper points out in her commentary, philosophers can usefully ‘proofread’ texts, pointing out contradictions, inconsistencies, ambiguities, and so on that can lead to misinterpretation or multiple interpretations. Philosophers may be useful in picking up problematic phrases, ambiguous definitions, and potentially troublesome phrases, as well as question the underlying framework of the psychiatric classification.

Another branch of philosophy, phenomenology, can be used to reveal, articulate and share experiences of suffering from a particular mental disorder. A ‘patient toolkit’ has been used to reveal what the actual experience of living with a condition may be like. This information is often taken for granted, but when shared with health professionals is often described as revelatory and inherently helpful, as well as not being otherwise available. Getz et al. have shown that treating individual diseases can be ineffective without have a deep understanding of the context in which illnesses take place, for example, historical abuse. This is another reason to seek such phenomenological accounts.

Third, experts are not enough. A consultative process should involve patients, carers, and families in a more formal capacity, and should recognise their unique knowledge of the meaning and impact of a particular psychiatric diagnosis (or its absence, or being misdiagnosed) and psychiatric condition. The full extent of a disease’s impact and the life of the patients and those around her can be made known using the ‘patient toolkit’ described above, but there is a need for patient testimonials as well as developing the appropriate listening skills in health professionals. For example, health

professionals should be told about the risk of epistemic injustice, so they can take steps to combat it (Carel & Kidd 2014).

This is particularly important in the domain of mental health, where high levels of distrust and alienation from mental health services are commonly reported. Mental health patient experiences have also given rise to a unique form of activism, denoted by their self-labelling as 'survivors of a mental health system'. This self-labelling appears only in mental health and is a notable contrast to other forms of self-labelling as 'survivors', e.g. 'cancer survivors', who have survived the disease, not the health care system geared to help them. These issues indicate a broader problem, that won't be resolved by work on the DSM alone, but should be taken into account when considering how to revise the DSM.

Philosophers and sociologists do have a role, but that role extends beyond Browne's proposal. One way to characterise the role is to say that it is to help health professionals develop epistemic humility, the ability to understand the partiality and biases of their position, and to accept that further revision will always be necessary. But that role needs to be played in the broadest possible way, through extensive engagement between the disciplines and embedding medical humanities into the medical curricula. It is also worth noting that philosophers and sociologists are not free from biases of their own, and therefore their reflective and critical capacities do not accord them the privileged position Browne suggests they are given.

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